Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN241AGC	A. BUILDING _____ B. WING _____	11/03/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON GROUP CARE #2	1240 E 10TH STREET RENO, NV 89512

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 11/3/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility received the grade of A. The facility is licensed for six Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness, Category I residents. The census at the time of the survey was five. Five resident files were reviewed and three employee files were reviewed. One discharged resident file was reviewed. The following deficiencies were identified:	Y 000		
Y 896 SS=C	449.2744(1)(b)(2) Medication / MAR NAC 449.2744 1. The administrator of a residential facility that provides assistance to residents in the administration of medication shall maintain: (b) A record of the medication administered to each resident. The record must include: (2) The date and time that the medication was administered.	Y 896		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 896	Continued From page 1 This Regulation is not met as evidenced by: Based on record review on 11/3/10, the facility failed to ensure the medication administration record (MAR) was accurate for 3 of 5 residents (Resident #1 - Fluoxetine, Resident #3 - Fish Oil, and Resident #5 - Clozapine). The caregiver did not initial the medication administration record to indicate the morning dose of medication was given for the entire month of October 2010. Severity: 1 Scope: 3	Y 896		